SAMHSA's Weekly Financing News Pulse June 1, 2009

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National Health Financing News

- **Senator Kennedy Circulates Draft of Health Reform Legislation**: **Senate Health, Education Labor and Pensions Committee Chair Edward Kennedy** (D-MA) is circulating a draft outline of his committee's health care reform legislation which he is expected to introduce on June 1. The proposal includes an individual health care mandate requires employer contributions to health insurance. The plan also calls for a government-sponsored public plan option to compete with private insurance and expands Medicaid eligibility to individuals with incomes up to 500 percent of the federal poverty level (FPL). The Washington Post reports that the plan "closely resembles" the Massachusetts health reform plan (Kaiser Daily Health Policy Report, 5/29; Washington Post 5/29). In related news, on May 27, **House Ways and Means Committee Chair Charles Rangel** (D-NY) characterized a Senate health care reform bill without a public plan option as "unacceptable" and said he believes that health care reform legislation without a public plan option would not successfully pass in the House (Bloomberg, 5/27).

- **Health Care Industry Groups Efforts to Reduce Health Care Costs Could Violate Antitrust Laws**: The **New York Times** reports that efforts on the part the **American Medical Association** (AMA), **American Hospital Association** (AHA), **Pharmaceutical Research and Manufactures of America**, **Advanced Medical Technology Association**, **America's Health Insurance Plans** (AHIP), and **Service Employees International Union** (SEIU) to reduce health care spending growth may be affected by U.S. antitrust laws (Financing News Pulse 5/26, 5/18 editions). Reductions in health care costs would likely involve setting maximum price increases and necessitate cooperation among health care providers. The **U.S. Department of Justice** (DOJ) struck down a similar plan attempted in 1993 that would have limited price increases for prescription drugs. At the time, the DOJ ruled that setting price maximums constituted an equal violation of antitrust laws as setting price minimums. In a letter to the **Senate Finance Committee**, the AHA asked Congress to amend the antitrust laws to make such cooperation easier (Kaiser Daily Health Policy Report, 5/27; New York Times, 5/26).

- **UnitedHealth Group Offers Recommendations to Reduce Federal Health Spending by $540 Billion Over 10 Years**: On May 27, **UnitedHealth Group's Center for Health Reform and Modernization** announced 15 recommendations that the company says may save the federal government $540 billion on health care over 10 years. The recommendations, which UnitedHealth sees as a first step towards fulfilling the promise made by sixth health groups to reduce the health care spending growth rate (Financing News Pulse 5/18, 5/26 editions and Above), include incentivizing the use of physicians rated the best in efficiency and quality and providing incentives to physicians for providing efficient care. UnitedHealth estimates that the government could save $166 billion by providing nurse practitioners at nursing homes to manage care and avoid unnecessary hospitalizations, $102 billion by using evidence-based case management and preventative care to reduce hospitalization, $57 billion by making administrative changes, including analyzing claims prior to payment, and $13 billion by reducing the use of medically unnecessary advanced imaging technology (Kaiser Daily Health Policy Report, 5/28; AP, 5/27).

- **Rep. Wolf Says Entitlement Programs May Affect U.S. Bond Rating**: In a letter to **President Barack Obama** on May 22, **Rep. Frank Wolf** (R-VA) cautioned that the U.S. may lose its AAA bond rating if Congress does not overhaul U.S. entitlement programs, including Medicare and Medicaid, and reduce the federal debt. Rep. Wolf co-authored a bill (**HR 1557**) to create a taskforce to address the growing costs and potential insolvency of Medicare and Medicaid. Under the legislation, the taskforce would

develop a package of recommendations to Congress for entitlement reform. **House Speaker Nancy Pelosi** (D-CA) and other congressional committee leaders oppose the bill, saying that Congress must pass a health reform bill before attempting entitlement reform (Kaiser Daily Health Policy Report, 5/26).

- **Sanofi-Aventis Settles Medicaid Charges**: Pharmaceutical company **Sanofi-Aventis**, wholly owned by **Sanofi-Aventis U.S. LLC**, agreed to pay $95.5 million to settle charges that it defrauded state Medicaid programs over the cost of three anti-inflammatory nasal sprays. The settlement, reached with the **DOJ**, resolves charges that the company did not offer state Medicaid programs the best price for the drugs between 1995 and 2000. Under the terms of the settlement, Aventis did not admit wrongdoing. More than half of the settlement funds will repay the federal government for its share of the Medicaid funding, $40 million will repay states for their share, and $6 million will compensate public health services firms for their losses (AP, 5/28; Wall Street Journal, 5/28).

- **CBO Report Details Budgetary Treatment of Health Reform**: On May 27, the **Congressional Budget Office** (CBO) released a report detailing the budgetary treatment of different types of health reform. The CBO said that a health care mandate would only constitute a new form of taxation if it takes the form of a public plan or of a tightly regulated private plan where premiums are paid to a government-run insurance exchange. **CBO Director Douglas Elmendorf** said that an individual insurance mandate coupled with an active loosely restricted public market where individuals pay premiums to non-governmental entities would not constitute a new federal tax (Kaiser Daily Health Policy Report, 5/28; Washington Post, 5/28). The report is available on the CBO's website.

- **At Least Six States Consider Reducing Aid for Medicare Drug Benefit**: The **Associated Press** (AP) reports that at least six states have considered reducing state-funded assistance for residents enrolled in the **Medicare Drug Benefit Program** (Part D) who are affected by the "doughnut hole" in coverage. Medicare pays for the first $2,700 of prescription expenses and for expenses over $4,350. The gap in coverage, which beneficiaries must pay out-of-pocket, is referred to as the doughnut hole. At least 16 states offer some financial aid to residents in the doughnut hole; however, lawmakers in Rhode Island, Vermont, and South Carolina have proposed eliminating the assistance. Massachusetts has reduced funding for such assistance and lawmakers in New York and Connecticut have dismissed proposals to limit assistance (Kaiser Daily Health Policy Report, 5/28; AP, 5/27).

- **Study Estimates Cost Paid Insured Residents to Cover Uncompensated Care**: A study released by **Families USA** and conducted by **Milliman** found that the average U.S. family and their employer paid an additional $1,017 in health care premiums in 2008 to cover the cost of uncompensated care. Uninsured individuals paid 37 percent of the $116 billion spent on health care for the uninsured in 2008 while government programs and charities paid another 26 percent. The study estimated the effect of the remaining 37 percent when spread across the insured population through higher premiums. The study found that an average single individual with private coverage pays $370 annually to finance uncompensated care (Kaiser Daily Health Policy Report, 5/28). The study is available on the Families USA website.

- **Study Projects Number of Uninsured Residents to Rise by 2010**: A study by researchers at the **University of California-San Diego** published in a recent issue of ***Health Affairs*** estimates that the number of uninsured U.S. residents will increase by at least 6.9 million by 2010. The researchers based their estimates on rising health care costs and average income. They note that the study does not

directly account for the rising rates of unemployment, which is also likely to increase the ranks of the uninsured (Kaiser Daily Health Policy Report, 5/28). An abstract of the study is available on the *Health Affairs* website.

- **NBGH Survey Finds One in Four Employees Ignore Medical Care to Cut Costs**: A survey conducted by the **National Business Group on Health** (NBGH) found that one in four employees choose to ignore medical care to save on out-of-pocket health care costs. The survey found that 27 percent of insured workers skipped treatment to avoid copayments and 20 percent did not take prescription medication for the same reason. The survey also found that 17 percent of respondents cut their prescription pills to make them last longer. NBGH conducted the survey in March and polled workers with union or employer-sponsored plans (CNN, 5/27).

- **Study Finds Few Retail Health Clinics in Low-Income Areas:** A study published in the ***Archives of Internal Medicine*** found that most retail health clinics are located in affluent areas of the U.S. rather than in low-income areas. They study found that communities with health clinics had lower African American and Hispanic populations, lower poverty rates, higher home ownership rates, and higher median incomes than average communities. Of the 930 retail clinics surveyed, only 123 were in communities classified as medically underserved. The study authors suggest these findings may contradict notions that retail health clinics will be a driving force in health care reform (Kaiser Daily Health Policy Report, 5/26). An abstract of the study is available on the journal's website.

- **Study Ranks Insurers by Speed of Claim Payment and Rate of Claim Denials:** A study prepared by **Aetnahealth** and ***Physicians Practice*** evaluated 172 national, regional, and governmental insurance payers in 40 states to develop rankings of claim payment speed and rate of claim denials. The study found that national health insurers paid physicians in an average of 33 days and denied an average of 9.2 percent of claims. In addition, the study found that insurers paid 5.3 percent faster in 2008 than in 2007 and denied 9 percent fewer claims. **Aetna**, **Cigna**, and **Humana** had the lowest rates of claim denials and ranked highest in speed of payment (Kaiser Daily Health Policy Report, 5/29). The complete rankings are available on the Aetnahealth website.

- **Report Finds Many Hospitals Fail to Report Disciplinary Actions Against Physicians**: On May 27, **Public Citizen** released a report that says few hospitals report cases of disciplinary action against physicians to the **National Practitioner Database.** Congress created the database in 1990 as a repository for information regarding doctors whose privileges are revoked for 30 days or more. Initially, the database was expected to receive 5,000 reports annually; however, an average of 650 reports were made annually since the database's creation. Public citizen sent a letter to **Department of Health and Human Services** (HHS) **Secretary Kathleen Sebelius** with recommendations to improve the efficacy of the database (Kaiser Daily Health Policy Report, 5/28). The report is available via Public Citizen's website.

- **Study Finds No Link Between Cost and Quality of Care in Elderly Patients:** A study conducted by researchers at **Dartmouth College** and **Harvard University** and sponsored by the **National Institute on Aging**, found no link between the quality and cost of health care in elderly patients. The study, published in ***Health Affairs***, examined data from chronically ill Medicare beneficiaries suffering form heart attacks, pneumonia, or congestive heart failure. Though the study found that spending varied from an average of $16,059 in the bottom 20 percent of hospitals to an average of $34,742 in the

highest 20 percent, there was no evidence of a link between cost and quality of care. The researchers noted that the indicators used may not have accounted for differences in the average level of sickness across hospitals and that the process-of-care measures used to determine quality of care may have affected the results (Kaiser Daily Health Policy Report, 5/27). An abstract of the study is available on the *Health Affairs* website.

- **Urban Institute Report Analyzes Massachusetts Health Reform**: A study by the **Urban Institute**, funded by the **Blue Cross Blue Shield of Massachusetts Foundation**, the **Robert Wood Johnson Foundation**, and the **Commonwealth Fund** and published in ***Health Affairs***, analyzed the continued effects of Massachusetts' health reform legislation passed in 2006. The study, "Update on Health Reform in Massachusetts", found that the law successfully increased access to care in the state; however, rising health care costs and the current recession are tempering those effects. In addition, the study found that residents had increasing difficulties finding physicians that accept the state-subsidized plan, with 24 percent of residents enrolled in the plan reporting that a physician did not accept their insurance. The survey also found that 91 percent of residents had a regular health care provider in 2008, compared with 86 percent in 2006 and that the percentage of low income families not receiving needed care dropped from 27 percent in 2006 to 18 percent in 2008 (Kaiser Daily Health Policy Report, 5/28). An abstract of the study is available on the *Health Affairs* website.

- **Report Finds Governments Spent $468 Billion on Drugs; Most Spending Health Care Related**: The **National Center on Addiction and Substance Abuse (CASA) at Columbia University** released a report analyzing federal, state, and local governmental spending on smoking, alcohol abuse, and substance abuse in 2005. The report found that 96 percent of the $467.7 billion governments spent on the drugs dealt with the consequences of substance abuse and 2 percent funded prevention and research. Of the share devoted to the consequences of substance abuse, 58 percent was for health care costs and 13 percent funded for criminal justice expenses (USA Today, 5/27; New York Times, 5/28).

- **FDA Issues Proposed Advertising Guidelines for Product Risk Information:** On May 26, the **Food and Drug Administration** (FDA) issued proposed guidelines for pharmaceutical companies and medical device manufacturers governing the presentation of risk information to health care professionals and consumers. The 24-page non-binding guidelines clarify FDA rules for balanced presentation of risk and effectiveness, including details on font and types of contrast for advertisements. The FDA is accepting public comment for 90 days prior to issuing final guidelines (Kaiser Daily Health Policy Report, 5/27).

- **KFF Publishes Issue Brief Examining Social Security Cost of Living Increases and the Effects on Medicare Part B:** The Financing News Pulse (5/11 edition) reported that Social Security beneficiaries will not receive cost of living increases in 2010 or 2011, causing 25 percent of Medicare beneficiaries to pay increased premiums for Medicare Part B. Most Medicare beneficiaries are protected from the premium increases, expected to rise from an average of $96.40 per month this year to $104 in 2010, and $120 in 2011, because of a law that ties social security increases to Medicare premiums. The **Kaiser Family Foundation** (KFF) brief outlines the three populations that will be affected by the premium increase: Medicare beneficiaries with adjusted gross incomes over $85,000 for individuals and $170,000 for married couples, new Social Security enrollees, and dually eligible Medicare

and Medicaid beneficiaries. However, Medicaid programs will pay the premiums for low-income dual eligibles (CQ Politics, 5/27). The brief is available on the KFF website.

- **Update: UAW to Accept Up to 20 Percent of GM Stock; Agrees to Retiree Health Care Concessions:** The **United Auto Workers** (UAW) have reached a deal with **General Motors** (GM) under which GM will give the UAW a 20 percent stake in the company to satisfy its **Voluntary Employees' Beneficiary Association** (VEBA) health care obligations. The UAW's share of the company is less than the expected 39 percent stake (Financing News Pulse 5/26, 4/20, 3/13, 2/20 editions), largely because of significant concessions on GM's retiree health care obligations. The deal eliminates dental, vision, and some prescription drug coverage for hourly retirees (Kaiser Daily Health Policy Report, 5/27).

- **MSNBC Creates Tool to Display State Budget Developments:** **MSNBC** created an interactive map to display state budget deficits and budget proposals for the coming fiscal year. The data is current as of May 25. The map is available via MSNBC's website.

Around the Hill: Hearings on Health Financing

Congress is not in session. The Senate reconvenes June 1 at 12:00 p.m. and the House reconvenes June 2 at 2:00 p.m.

Around the States: State and Local Behavioral Health Financing News

Alabama

- **Alabama Settles Medicaid Lawsuits with Six Pharmaceutical Companies for $89 Million**: In 2005, Alabama sued 72 pharmaceutical companies for manipulating drug prices paid by the state Medicaid program and overcharging for drugs (Financing News Pulse 2/27 edition). Six companies—**Abbott Laboratories**, **Aventis Pharmaceutical L.P.**, **TEVA Pharmaceuticals USA**, **Shering-Plough/Warrick Companies**, **Forest Laboratories,** and **Baxter International**—settled with the state this week, agreeing to pay a total of $89 million. The state plans to use most of the settlement funds for the general fund. Alabama previously settled with 10 companies for roughly $35 million and won judgments against four companies totaling $352.4 million (AP, 5/22; Dow Jones Newswires via CNN, 5/22).

California

- **Officials Detail Governor's Proposed Budget Including Health Care and Welfare Cuts**: After voters rejected five propositions that would have reduced the state's budget deficit from $24.3 billion to $15.4 billion, the Department of Finance announced **Governor Arnold Schwarzenegger's** (R) proposed health care cuts as part of a package designed to close the state's budget deficit (Financing News Pulse 5/26, 5/4, 3/6, 2/20 editions). Governor Schwarzenegger's plan, which cuts $2 billion from health and human services, would eliminate the State Children's Health Insurance Program (SCHIP), **Healthy Families**, saving the state $250 million and terminating coverage for 900,000 low-income children. In addition, the plan would cut $750 million for **Medi-cal**, the state's Medicaid program, including eliminating dialysis and breast cancer treatment for elderly women and non-emergency care for undocumented immigrants. In addition, Governor Schwarzenegger's proposed budget eliminates the **California Work**

Opportunity and Responsibility to Kids Program (CalWORKS), the state's "welfare" program, saving the state $1.3 billion and losing three times as much in federal funding (Kaiser Daily Health Policy Report, 5/27; Sacramento Bee, 5/27).

- **Lake County Board of Supervisors Approves $1 Million Loan for Mental Health Department**: On May 26, the **Lake County Board of Supervisors** approved a $1 million loan to help the **Mental Health Department** pay its $2.3 million in outstanding vendor invoices. The move comes after the county transferred realignment funds to the department one week earlier. The department now owes Lake County a total of $2.4 million. In addition, California is currently withholding payments from the county's mental health department stemming from state overpayments that occurred between 1999 and 2006 (Financing News Pulse 4/20 edition) (Lake County News, 5/27; Lake County News, 23).

- **Sacramento County Mental Health Center Temporarily Suspends Admissions**: On May 22, the **Mental Health Treatment Center** in Sacramento County, the county's main psychiatric hospital, announced it is not currently accepting new patients and will not resume doing so until it reduces its caseload. The move came after state officials warned hospital officials that their current caseload—over the stated maximum—would result in sanctions. The hospital's crisis center handles seriously mentally ill patients that are considered threats to themselves or others. Mental health advocates worry that the move indicates weakness it the county's mental health system (Sacramento Bee, 5/27). Sacramento County has cut $10 million for mental health services since June 2008 and faces an additional $18.4 million in cuts after July 1 (Sacramento Bee, 5/28).

- **Update: Stanislaus County Cuts Behavioral Health Funding**: On May 26, the **Stanislaus County Board of Supervisors** approved $4.5 million in cuts to the Behavioral Health and Recovery Services' $64.5 million budget. The cuts included eliminating 47 vacant positions and 5 staff members—12 fewer than the 73 positions slated for elimination in initial projections (Financing News Pulse 4/27 edition) (Turlock Journal, 5/22).

- **Mental Health Center Planned for Prison in San Luis Obispo**: The **Department of Public Works** is overseeing the construction of a $63.7 million mental health center at the California Men's Colony in San Luis Obispo. The funding for the facility comes from the state's lease-revenue bond designated for jail construction under **AB 900**, signed by **Governor Schwarzenegger** (R) in 2007. The facility is scheduled to open in 2013 (San Luis Obispo Tribune, 5/26).

Florida

- **Governor Signs Budget, Vetoes State Employee Pay Cut**: On May 26, **Governor Charlie Christ** (R) signed a $66.5 billion state budget, vetoing a pay cut for state workers earning $45,000 or more annually. The budget cuts Medicaid hospital reimbursement rates by up to 1.6 percent, HMO reimbursement rates by slightly less than 1 percent, and nursing home reimbursement rates by 3 percent in addition to reducing funding for home and community-based elderly care. The budget also includes a $1 per-pack increase in the state cigarette tax (Financing News Pulse, 5/18 edition; Miami Herald, 5/27).

- **Miami-Dade County and BCBS Offer Affordable Comprehensive Health Plan**: Miami-Dade County and **Blue Cross Blue Shield of Florida** (BCBS) are offering a new preferred provider organization (PPO) plan designed to offer affordable comprehensive health care to the 600,000 uninsured residents of Miami-Dade. The plan, **Miami-Dade Blue**, is open to individuals up to age 65 and employers with 50 or fewer workers; however, BCBS can reject individuals for preexisting conditions. Though the benefits offered are less than in most popular plans, the premium for a healthy 35-year-old male would be roughly $100 monthly and the plan would pay 90 percent of in-network hospital expenses and 100 percent of in-network lab tests after a $250 deductible. In addition, generic prescriptions are available for $10 copayments; however, brand-name drugs are not covered. The plan is not funded with taxpayer dollars (Miami Herald, 5/27; Kaiser Daily Health Policy Report, 5/28).

Iowa

- **Governor Signs Bill Imposing Nursing Home Fee to Fund Medicaid**: On May 26, **Governor Chet Culver** (D) signed legislation (**SF 476**) imposing a 3 percent quality assurance fee on nursing homes for each patient day. The fee, which does not apply to state nursing facilities, is expected to generate $33 million that will be used to provide supplemental Medicaid payments and draw down an estimated $45 million federal match. The state Legislative Services Bureau determined that most nursing homes will see a net revenue gain from the fee; however, nursing homes with few Medicaid patients will suffer a net loss. Thirty-three other states use similar nursing home fees (Waterloo-Cedar Falls Courier, 5/27).

- **Iowa's Budget Increases Health and Human Services Funding**: Iowa's health and human services budget (**HF 811**) will increase from $1.28 billion in the current fiscal year to $1.43 billion in the coming two-year fiscal year, including $174 million in American Recovery and Reinvestment Act (ARRA) funding. This funding includes the SCHIP expansion that raised the income eligibility cap from 250 percent of the FPL to 300 percent of the FPL (Financing News Pulse 5/26 edition) (Des Moines Register, 5/26).

Kentucky

- **Attorney General Settles with Eli Lilly over Medicaid Fraud**: **Kentucky Attorney General Jack Conway** settled with **Eli Lilly and Co.** over allegations that the company improperly marketed its antipsychotic, Zyprexa. Under the terms of the settlement, Eli Lilly will pay Kentucky $5.1 million but not admit to any wrongdoing. Roughly $3.8 million of the settlement funds will go to the Kentucky Medicaid program and the remainder will go to the state's general fund (Business First of Louisville, 5/26).

Maine

- **Governor Approves State Budget; Cuts Some Medicaid Reimbursements and Raises Others**: On May 28, **Governor John Baldacci** (D) signed a $5.8 billion two-year state budget, approved by the Legislature earlier in the week. Among other cuts, the budget reduces Medicaid reimbursement rates for critical access hospitals in rural areas but increases reimbursements for private physicians (AP via NBC, 5/28; Bangor Daily News, 5/28).

Michigan

- **State Attorney General Files Petition to Block BCBS Rate Increases**: On May 21, **State Attorney General Mike Cox** (R) filed a petition to stop non-profit **Blue Cross Blue Shield of Michigan** (BCBS) for increasing

rates for 400,000 individual policyholders. BCBS' proposed rate hikes would be 56 percent for non-elderly residents buying their own insurance, 42 percent for policyholders with group conversions, and 31 percent for seniors with Medigap policies. BCBS says the rate increases counteract growing loses the company has suffered in the individual market. The **Office of Financial and Insurance Regulation** must schedule a hearing on the petition by July 2 (Kaiser Daily Health Policy Report, 5/26; Detroit Free Press, 5/22).

Minnesota

- **DOJ and HealthEast Reach Settlement Over False Medicare Claims**: On May 28, **HealthEast Care System** agreed to pay $2.28 million to settle a **DOJ** lawsuit alleging that three of the company's hospitals filed false Medicare claims. The lawsuit alleged that HealthEast's hospitals performed a spinal-repair procedure as an inpatient service rather than an outpatient service to increase the hospitals' Medicare funding (Minneapolis/St. Paul Business Journal, 5/21).

Mississippi

- **Update: Lawmakers Fail to Strike Medicaid Funding Compromise to Pass the Budget**: House and Senate negotiators have yet to resolve budget differences stemming largely from differing methods of resolving a $90 million Medicaid shortfall (Financing News Pulse 5/26, 5/11 editions). The AP reports that, as of May 28, the two sides were moving further apart. The House is now seeking to fill the Medicaid gap with funds from the state's $939 million "rainy day" fund (Memphis Commercial Appeal, 5/28; Commercial Dispatch, 5/28; AP via WLOX, 5/28).

Missouri

- **Governor Seeks to Compel Colleges to Use Funding for Health Care Professionals**: In the budget passed this year, the Missouri Legislature included $33.5 million in ARRA funding to be divided between Missouri's 10 universities and a technical college for "any one-time purpose." However, **Governor Jay Nixon** (D) is encouraging school officials to use the funds to expand the number of classroom slots available for health care professionals. Governor Nixon wanted the funding for his "Caring for Missourians" plan, which he designed to produce an additional 916 health care graduates with roughly $40 million in higher education funding. However, legislators elected to give schools leeway with the funding and the governor is now attempting to persuade schools to fund health care education (AP via Belleville News-Democrat, 5/24).

Nebraska

- **Update: Governor Signs Children's Behavioral Health Bill**: On May 22, **Governor Dave Heineman** (R) signed behavioral health legislation (**LB 603**) into law. The legislation, which includes five separate proposals, raises the income eligibility cap for the SCHIP**, Kids Connection**, from 185 percent of the FPL to 200 percent of the FPL, adds Medicaid reimbursement for community-based behavioral health services, expands services for families by allocating funds to Nebraska's six behavioral health regions, and creates a 24-hour helpline. The legislation also establishes the **Behavioral Health Education Center at the University of Nebraska Medical Center** to increase the state's supply of mental health professionals. Finally, the bill creates a legislative committee to oversee the implementation of the new

initiatives (Financing News Pulse 5/26, 5/11, 2/27 editions) (Office of the Governor of Nebraska via All American Patriots, 5/22).

New Jersey

- **Legislature Approves Bill Requiring Pharmacists to Inform Consumers of Generic Drug Substitutions**: On May 21, the New Jersey Senate passed a measure (**A 2030**) requiring pharmacists to inform consumers when they substitute generic drugs for brand-name prescriptions. The General Assembly passed the legislation in February (Star-Ledger, 5/22; Kaiser Daily Health Policy Report, 5/26).

- **Governor Asks Commissions to Review Proposals to Temper Rising State Health Premiums:** On May 22, **Governor Jon Corzine** (D) ordered the **State Health Benefits Commission** and the **School Employees Health Benefit Commission** to review his proposed reforms for the state employee health plan. The governor's plan would place tighter controls on employers participating in the plan—including imposing penalties for late premium payments. The governor did not detail the specifics of his proposals (Star-Ledger, 5/22).

New York

- **Orange County Medicaid Enrollment Up 16 Percent**: Orange County officials report that the county's Medicaid enrollment has increased 16 percent from March 2008 to March 2009. Medicaid enrollment for the county now totals 17,212 residents. Orange County spent $67.5 million this year for its share of the state's Medicaid program. In New York, counties pay 25 percent of Medicaid costs (Times Herald-Record, 5/26).

North Carolina

- **House Budget Writers Propose Health Cuts**: Facing a $4.6 billion budget gap, House budget writers have proposed cutting over $1 billion from health programs. The cuts include $91 million in reduced Medicaid reimbursement rates for doctors and hospitals, $49 million in reductions to home care services, and $50 million in cuts for mental health, substance abuse, and developmental disabilities (WRAL, 5/28; NBC, 5/28; AP via Forbes, 5/27).

Ohio

- **Pharmaceutical Companies Settle Ohio Medicaid Billing Charges**: **Abbott Laboratories**, **Pharmacia**, Roxane **Laboratories,** and **Warrick Pharmaceuticals** will pay Ohio $8.44 million to settle five-year-old allegations of improper drug pricing for the state's Medicaid program. Under the terms of the settlement, Abbott will pay $1.34 million, Pharmacia will pay $400,000, Roxane will pay $2.4 million, and Warrick will pay $4.3 million. All four companies deny wrongdoing (Med City News, 5/28; Business First Columbus, 5/28).

- **Madison County Commissioners Approve Ballot Language to Extend Mental Health Levy**: On May 26, the **Madison County Commissioners** approved ballot language for the renewal of the levy funding the Mental Health and Recovery Board of Clark, Greene, and Madison Counties. The language calls for a renewal of .5 mil levy for each dollar of valuation—roughly 5 cents for every $100 of valuation—and will

appear on the November 3 ballot. Unlike previous extensions, the language will extend Madison County's levy for seven years instead of five (Madison Press, 5/27).

- **Tiffin City Board of Education Approved Mental Health Funding for Schools**: On May 26, the **Tiffin City Board of Education** approved a $42,500 Mental Health & Recovery Services Board grant, funded by the district mental health levy. Tiffin schools will use the funding to provide counseling for at-risk students and plan to combine the grant with other funding for a total of $85,000 for counseling services (Advertiser-Tribune, 5/27).

Pennsylvania

- **Blue Cross Seeking Rate Increases for Individual Health Plans**: Non-profit **Independence Blue Cross** is seeking rate increase of 20 to 58 percent for individuals and families purchasing individual plans. The company's proposed cuts, which are currently under consideration by the **Insurance Department**, would affect roughly 30,000 residents beginning July 1. The company says the rate increases are necessary because it was paying out more in claims than it was collecting in premiums (Kaiser Daily Health Policy Report, 5/26).

- **Delaware County and Philadelphia No Longer Referring Patients to Friends Hospital**: Beginning July 1, the **Philadelphia Department of Behavioral Health and Mental Retardation Services** will no longer refer patients to **Friends Hospital's** crisis center. Delaware County has already halted referrals to both the crisis center and the hospital's inpatient unit. The city of Philadelphia referred roughly 6,500 cases to the Friends Hospital last year. The loss of those cases will cost the hospital roughly $2 million. Both the city and the county believe the quality of care at the Philadelphia hospital is insufficient (Philadelphia Inquirer, 5/22).

Tennessee

- **Governor's Budget Proposal Cuts Staff for State Mental Health Offices, Restores Safety Net Funding**: As part of a proposal to save $112 million in the current-year budget and $161 million from the FY2009-2010 budget, **Governor Phil Bredesen** (D) has proposed eliminating 656 vacant positions and laying off 717 state employees. Under the plan, the **Mental Retardation Services Division** and the **Department of Mental Health and Development Disabilities** (DMHDD) will lose 552 positions. However, the plan also restores $10 million in planned cuts to the DMHDD for mental health safety net services. Layoffs are slated to occur by June 2010 (AP via Forbes, 5/27; Office of the Governor via Knox News, 5/27).

Texas

- **Senate Passes SCHIP Expansion, Governor May Veto**: The Texas Senate passed legislation to expand SCHIP by raising the income eligibility cap from 200 percent of the FPL to 300 percent. However, **Governor Rick Perry** (R) said he will consider vetoing the SCHIP legislation unless it is approved by the full Legislature (Financing News Pulse 5/26 edition) (Houston Chronicle 5/24; Houston Chronicle 5/28; Houston Chronicle 5/29; Dallas Morning News 5/29; Kaiser Daily Health Policy Report, 5/29).

- **Dallas County Judge Rules Green Oaks Facility Must Pay Legal Fees for Involuntary Mental Health Commitments; Green Oaks May Refuse Admissions**: Probate Judge Michael Miller has ordered Green

Oaks, a private psychiatric hospital, to follow a Texas law requiring the facility to pay court costs and attorneys' fees for poor patients who are involuntarily committed due to severe mental illness. The fees apply only to private facilities but Green Oaks admits the patients because no public facility exists in Dallas County. The previous judge, Joe Loving, waived the fees. Green Oaks is refusing to pay the $1 million in back fees that Miller has assessed and plans to give the county 90 days notice before halting the admission of involuntary commitments (Dallas Morning News, 5/27).

Vermont

- **Vermont to Participate in Initiative to Test Models for "Dual Eligibles**": On May 26, **Governor Jim Douglas** (R) announced that Vermont is one of seven states (CO, MD, MA, MI, PA, TX, and VT) participating in a program to test innovative models to improve care and control cost for "dual eligibles," individuals eligible for Medicaid and Medicare. The **Center for Health Care Strategies** (CHCS) designed the program, Transforming Care for Dual Eligibles, which is also sponsored by the **Commonwealth Fund.** In Vermont, the program will create a pilot using Vermont's Medicaid waivers to create a Special Needs Plan (SNP) to provide integrated care and billing to dually eligible individuals. Over the 18-month program, Vermont and the other participating states will receive extensive technical training and work with the **Centers for Medicare & Medicaid Services** (CMS) to identify new methods for Medicare-Medicaid integration (Vermont Business Magazine, 5/26).

Washington

- **DSHS to Cut Pharmacy Medicaid Reimbursements**: On May 22, the **Department of Social and Health Services** (DSHS) announced a 2 percent cut to the prescription drug reimbursement paid by the state's Medicaid program. The cut, effective July 1, will reduce the reimbursement rate from 86 percent of the average wholesale price for brand name prescription drugs to 84 percent of that price. The reduction will save $12 million in combined state and federal funds. DSHS previously attempted to reduce the Medicaid prescription drug reimbursement rate to 80 percent of the average wholesale price but state pharmacies sued and the state dropped the proposal (Financing News Pulse 5/18, 4/27, 4/6 editions) (AP via Spokesman-Review, 5/24).

- **ElderHealth Northwest to Cut Staff and Close Facilities Due to State Budget Cuts**: On May 26, **ElderHealth Northwest**, Washington's largest provider of community-based care for the elderly, announced it will lay off 40 employees in King and Snohomish Counties and close two of its six centers. ElderHealth estimates that roughly half of the elderly patients it serves will lose Medicaid coverage on July 1 when the state's 70 percent cut in Medicaid funding for low-income seniors takes effect (Financing News Pulse 5/26 edition)(Seattle Post Intelligencer, 5/26).

West Virginia

- **Update: Taskforce Recommends Spending Half of New Mental Health Funding on Medicaid**: The Financing News Pulse (5/26, 5/18, 5/11 editions) reported that **Governor Joe Manchin** (D) vetoed legislation (**SB 672**) that would have added $12.7 million to Medicaid for mental health funding. Instead, the governor pledged to spend an equal amount on mental health without restricting funding to the state's Medicaid program. The state's **Behavioral Health Commission** formed a taskforce to issue

recommendations for allocating the $12.7 million. Among other proposals, the taskforce recommended spending half to the funding to increase Medicaid reimbursement rates for mental health services (Charleston Gazette, 5/26). Lawmakers say an override vote on SB 672 is unlikely because the bill's supporters are satisfied with the governor's efforts (AP via Forbes, 5/27).